THE FUTURE OF COMMUNITY SERVICES

IN

HAMILTON-WENTWORTH

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A DISCUSSION PAPER

BY

SOCIAL PLANNING AND RESEARCH COUNCIL
OF HAMILTON-WENTWORTH

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INTRODUCTION

The purpose of this paper is to contribute to discussion and debate about the future of social services in Hamilton-Wentworth. One of the primary functions of the Social Planning and Research Council is to monitor trends in the community and to extrapolate the implications of these trends with respect to the quality of life for the residents of the Region. This paper arises out of our attempts to monitor trends in the delivery of community services and the environment in which they operate.

The paper argues that current trends in service delivery are consistent with a new model of intervention which builds upon the experiences of the past decades and which differs, in fundamental ways, from traditional approaches. The emerging model closely approximates an approach to human service delivery which has been described as "capacity-building" in the work of John McKnight and Jody Kretzman of Northwestern University.

The paper also argues that the advantages of this new model may lie in issues of access rather than effectiveness. Although traditional models may be effective in addressing the needs of individuals who access the services, they are very limited with respect to the number of persons they can serve, given the magnitude of demand in the community. As a result, community problems continue at unchanging or increasing rates, despite the significant investment of funds in the human services sector.

The paper also continues the work of the Region's Sustainable Development Task Force with respect to the structure of community services. The Task Force envisioned a future structure in which persons could access a variety of services in one location within their community or neighbourhood. This represents a significant departure from the current structure of relatively specialized agencies which operate, predominantly, in the downtown core.

This paper is therefore intended as a catalyst to discussion with respect to a number of key issues-

1. Does the capacity-building model reflect the evolutionary direction of change which is underway in local community services?
2. Does it have the potential to assist a greater number of people and better address community problems, without a loss of effectiveness at the level of individual clients?

3. If the capacity-building model reflects a desirable vision for local services, should we be taking planned actions to "speed-up" the rate of change.
4. What are the current obstacles to increasing the prevalence of capacity-building interventions in the community and how can they be resolved?
5. Does a system of neighbourhood-based or community-based multi-service centres represent a preferred structure to that of our current system?

THE DEVELOPMENT OF HUMAN SERVICES

The earliest phase in the development of the human services system was marked by a dominance of religious institutions and the voluntary sector with only minimal government involvement in basic child welfare services and some income maintenance programs. Churches and local United Appeals provided the bulk of funding for personal social services and, philosophically, the system was rooted in the notion that communities contained a number of "deviants" or "abnormal" persons who needed help in adjusting to "normal" life. Human services were therefore viewed as special agents of socialization for a few people for whom the traditional means of socialization such as families and schools had failed. It was not expected that a significant proportion of the population would ever need to avail themselves of the services offered.

It was also an era dominated by large residential care institutions for individuals suffering from chronic disabling conditions, based on the notion that it was best to remove them from the community and allow them to live in a sheltered institutional setting.

There was relatively little professional training available for staff within the services. In the early nineteen sixties, for example, a local survey by the Social Planning and Research Council reported that only a small proportion of persons employed in the social services system had any professional training with respect to counselling and therapeutic interventions. Many workers came to the system from a background in the church and to a great extent the system was dominated by a pastoral ministry approach to serving the population.

Community agencies were governed by Boards of Directors who played a strong role in agency administration because of a perceived lack of administrative skill among agency managers. The number of agencies within the community was significantly less than today.

This era in community services began drawing to a close during the nineteen sixties with the entrance of the Federal Government into the social development field in a major way. The passage of the Canada Assistance Plan cleared the way for significant federal expenditures in the social development area under cost-sharing arrangements with the provinces. As the funding role of government increased, the resource role of churches and local charities were diminished correspondingly. In Ontario a funding formula was devised which meant that many programs required only twenty percent of their funding from local community sources while the Federal and Provincial Governments provided fifty and thirty percent respectively.

As the community services sector grew with this influx of funding, the demand for accountability and professionalism grew correspondingly. The growth of the university system, particularly in the social sciences, resulted in the availability of more and more trained personnel for agencies as a clinical model of intervention began to dominate the system. This clinical model was largely based on the traditional "doctor-patient" relationship of psychology and psychiatry, insofar as the basic interaction was a one-to-one interaction between the trained clinical expert and the person in need in a counselling situation.

For a brief period in the late sixties and early seventies, the clinical model co-existed with a community development social activism model of social interventions. While the clinical model was primarily geared towards changing the individual who was experiencing the problems, the community development social activism model was directed towards changing the social conditions which were believed to be at the root of the individuals problems. The marriage of social activism and government funding, however, proved to be fraught with difficulty and the clinical model grew to dominate the community services system. By the nineteen eighties, the vast majority of community service funding was invested in clinical interventions.

It was also during this period that the other hallmark of the earlier era - the large residential care institutions - underwent significant changes as the notion of "de-institutionalization" began to dominate social policy, beginning with the mental health system in the nineteen seventies. The emphasis upon bringing people out of the institutions and the provision of community supports to help them exist in the community moved to the forefront. There was, consequently, a rapid growth in small residential care facilities such as group homes and homes for special care, often located in residential areas of the community.

Most significantly, there was also a turning away from the traditional notion that community services existed solely for the benefit of a few "deviants" as it was increasingly recognized that a large proportion of the population encountered problems which required social service interventions at some point in their life. The client base grew to embrace a larger and larger share of the population.

It is this model of human services which currently operates in our community and across the Country. During the eighties, when the era of expansion drew to a close, there was an increased emphasis upon co-ordination in service delivery as the number of individual agencies and programs multiplied. The quest for improved co-ordination was typically undertaken through the formation of various co-ordinating bodies which brought together senior representatives from relevant agencies to focus on problems of mutual concern related to planning, priorities, information exchange and, in some cases, joint programming. Hamilton-Wentworth is generally recognized as a "lead-community" with respect to these kinds of activities.

In more recent years, the focus on improved co-ordination has intensified into proposals respecting the actual amalgamation of agencies. This trend is most pronounced in recent government initiatives pertaining to long term care reform.

In general, then, the era of expansion in human services which marked the early sixties to the early eighties has been replaced by a focus on re-structuring services with relatively little growth in the overall service system.

There appears to be a growing recognition among planners, funders and direct providers of human services that the system is now at a "watershed" which is reminiscent of the early sixties. The model of delivery which had grown out of that period has dominated the system for the past three decades and much has been learned from the experiences which have been gained. Recent discussions of "future directions" in human services, in addition to issues of restructuring, have increasingly been dominated by discussions pertaining to the need for new models or philosophies of delivery. The potential need for change has been driven both by changing external circumstances and an increasingly informed internal debate about the effectiveness and efficiency of the dominant model of social intervention.

THE CHANGING ENVIRONMENT

The late eighties and early nineties represented a period of profound change in our society and no sector of our community was immune to these influences. The human services system has been forced to contend with a number of dramatic trends which have arisen from the changes within the community which it serves.

1. Fiscal Restraints

The growth of government deficits during the eighties has resulted in dramatically increased pressure for spending constraints at all levels of government. Social policy expenditures, which account for a large share of public spending, have not been immune to these pressures and, as a result, resource growth has slowed, disappeared and in some cases diminished. This situation is not expected to change significantly during the decade of the nineties.

2. Increased Social Disruption

The economic disruption of the past five years has taken its toll on our communities social fabric. This has inevitably resulted in increased demands in service, despite a lack of growth in resources.

3. Increased Influence of Poverty

Poverty is a basic underlying core cause of a considerable portion of social problems and social service demand. The economic disruption of the past five years has dramatically increased the level of poverty in the community and consequently, many of the undesirable "symptoms" of this condition in the community are expected to increase.

4. A Reversion to Basic Needs

The increase in poverty and financial hardship has resulted in an unprecedented increase in the demand for services that address the most basic needs for food and shelter. The dramatic growth in food banks has been one of the more obvious expressions of this dynamic. Because these needs had been of a lower priority for most of the past two decades, there were relatively few formal social service resources directed at this level of need outside of the income maintenance system. Most social service resources were

consequently "locked up" in sectors which served higher levels of need and, consequently, the securement of resources to address basic needs has been problematic.

5. Growing Dominance of Family Violence

A variety of developments, including the mandatory reporting of child abuse, the increased awareness of women's issues and the effects of the recession on the family have served to dramatically increase the reporting and perhaps the incidence of family violence. As a result, traditional agencies which serve the family have found that their caseloads are increasingly dominated by family violence issues and other areas of family intervention have been reduced to accommodate this shift.

6. Emergence of Self Help and Consumer Rights

The self-help sector has grown dramatically during the past decade as more individuals have opted for this approach to addressing individual problems. Many agencies have responded to this trend by incorporating self help modalities within their programming. At the same time, strong consumer groups are demanding a greater voice in the allocation and distribution of social resources in the community.

7. Cultural Diversity

The dramatic growth in the cultural diversity of the community has resulted in a dramatic challenge to the ability of mainstream agencies to offer relevant services in an accessible manner to an increasingly large segment of the community.

8. Patterns of Accountability and Governance

The need to redefine the role of Boards of Directors and accountability for agency services has resulted in changed concepts of governance as reflected in the Policy Governance Model and an exploration of the process of outcome funding to agencies and direct funding to consumers by funding bodies.

9. Emerging Critiques of the Clinical Model

Two to three decades of intensive experience with the clinical model of service delivery has resulted in an inevitable critique of that approach to addressing community problems. Problems of cost, limited accessibility in the face of increasing demand and, in some cases, limited success has resulted in growing discussions about the need for new models of intervention based upon self-help, community development, prevention and capacity-building.

10. Demographic Shifts

The changing demographic structure of our population continues to impact upon services as different age groups expand and contract with the passage of the post-war baby boom through the life cycle and as life expectancies continue to increase. The need to provide cost-effective services to the increasing number of elderly persons in the community continues to challenge the public sector.

11. Continued De-institutionalization

The ongoing shift from institutional care to community care continues to challenge the ability of the community to absorb populations which were previously housed in institutions. The creation of a truly inclusive community will remain a challenge for the foreseeable future.

12. Emphasis on Simplified Access

The rapid growth of the human services system during the past two decades has resulted in a perception of an uncoordinated and complex system of services. Government initiatives are increasingly focussed upon amalgamation of services and models of coordinated service access rather than the creation of new services. The most dramatic expression of this trend has been the reform of Long-term Care services in Ontario but similar models are being reviewed in almost all service sectors.

INTERNAL FACTORS

In addition to the profound importance of these external factors, the current system of services is also being influenced by important forces from within as the growing experience with models of service leads to greater knowledge about the effectiveness of various interventions. For example, caseload pressures have led to growing interest in self help modalities and various models of "brief" therapies.

One of the land-mark studies in Ontario which has led to serious re-examinations of current models of intervention was the 1986 Ontario Child Health Study. This study was the most rigorous epidemiological examination of the problems of children in the history of the Province. The study focussed upon a number of diagnostic categories of emotional problems in children and concluded that, among children exhibiting symptoms consistent with these categories, less than one in five had any contact with a "helping" service. Given that all children who are in contact with helping services are not helped by their contact, these results tended to reinforce concerns about the actual level of impact that our current models were having on the problems of children in our society.

At the time of the study, children services across the Province were contending with caseloads which heavily taxed current resources so the answer to this problem did not simply lie in the development of more case-finding interventions. If more children were introduced to the system of services, the system would not be able to absorb the potential demand that these new clients would represent. At the same time, it was generally recognized that the kind of resource increase that would be required to expand the contact rate to even thirty percent of the children in need was not feasible.

The results of this re-examination has increasingly led to the development of a "reluctant" conclusion - It is unlikely that our current system of children services will ever have the kind of resource base required to have a significant impact on the problems of children in the Province, based on the models currently employed. Although this analysis is based upon the children's services system, it is quite likely that the same conclusion is valid for most community service sectors. The children's system is simply the sector which has been most rigorously examined.

These conclusions lead to a very serious issue pertaining to the role of human services within society. If human services exist for the purpose of helping those individuals who are fortunate enough to access the service system, then the current situation is unfortunate but perhaps it is what we must live with, given

resource constraints. If, however, the purpose of the human services system was to have a significant impact upon the human problems of the community, then we are failing badly. The limited accessibility that people had to the system was threatening to make the services irrelevant to the problems of the community. This lingering concern was further ignited by the profound disruptions of the early nineties when economic circumstances conspired to dramatically increase the incidence of problems in the community while, at the same time, diminishing the resources available to agencies whose mission it was to address these problems.

These concerns were not unique to the traditional social services sector. They were also at the centre of an increasingly vocal debate in the health sector. In this case, there was an increased controversy between traditional clinical health service providers and the advocates of "population health" who argued that significant advances in the health status of the population occurred as a result of factors that had very little to do with traditional clinical services - improved nutrition, improved sanitation, the alleviation of poverty and other social or public health interventions. The health sector is currently in the midst of a transformation which is attempting to decrease its reliance upon clinical interventions and increase the role of population health measures. It is a reformation which is very similar to that which is looming in the social services sector.

With increased regularity during the eighties, the priorities which were being identified by service providers involved interventions which were not of a clinical nature. In a 1991 overview of the priorities which had been identified in eighteen different service sectors in Hamilton-Wentworth, the SPRC identified three general conclusions about the direction which the local human services system appeared to be taking -

1. A shift away from traditional counselling/residential services towards a model which places more emphasis upon facilitating the ability of clients to function in the community through -
   a. skill development
   b. instrumental supports
   c. self help/mutual aid strategies
2. A possible shift away from treatment models which implicitly emphasize client dependency on the helping-system to models which emphasize client independence and empowerment through modalities identified in "1" above.
3. An increased emphasis upon coordination in assessment and referral through multi-disciplinary collaboration.

At a Provincial level, the shift in thinking with respect to interventions was most recently reflected in the May 1994 report on children and youth by the Premier's Council on Health, Well-Being and Social Justice, in their report entitled, Yours, Mine and Ours. This report recommended that a "population approach" be taken in responding to issues affecting children and youth which stood in clear contrast to more traditional models. The discussion focussed upon outcomes, the need for broad-based community partnerships and a re-thinking of how mainstream and specialized services address the problems of this component of our population. Relatively few of their program-specific recommendations were related to traditional clinical intervention models.

The problems in implementing these shifts were both financial and political. There was very little funding available for new programs and funding for existing programs was rigidly tied to traditional modalities of service. As a consequence, agencies did not have the flexibility to use their existing resources to support new directions in programs while, at the same time, there was very little money available to support new initiatives. Local funders attempted to respond to this problem by emphasizing innovation. The United Way, for example, created their Demonstration and Development Fund and the Hamilton Community Foundation created a special fund for innovative initiatives pertaining to children and youth. Although these initiatives have played an important role in supporting local innovations, the amount of money available is not large, relative to the enormity of the provincial investment in human services and it was this component that remained rigidly entrenched in traditional modalities.

For a brief period of time in the late nineteen-eighties, the growing interest in human service reform was accompanied by a corresponding interest in devolving greater control over human services to local communities. One of the leading proponents of this approach was the Premier's Council on Health Strategies and their reasoning was based on the recognition that effective reform was more likely to occur if communities were given more autonomy. Interest in devolution waned, however, with the election of a new Provincial Government and a growing pre-occupation with economic issues.

In summary, then, the experiences of the past decade have led to concerns about the ability of the traditional services model to have a meaningful impact upon community problems because of the limited accessibility which it provides. New models and initiatives have grown out of these concerns but their implementation has been hampered by a lack of funding for new programs. As a result, the vast majority of social policy expenditures remain tied to traditional intervention models. . . . . .

THE EMERGING MODEL

The purpose of this section of the discussion paper is to attempt to articulate the "new model" of service delivery which appears to be coming to the fore, based on all of the influences described above. Given that this model has not yet fully emerged for analysis and clarification, the model that will be described here is tentative in nature and open for much debate, discussion and clarification.

It is clearly a model which is moving away from the traditional clinical approach which was based upon persons in need approaching an "expert" counsellor for advice and guidance about how they should address their problems. Under the new approaches, the role of the counsellor changes from one of expert to facilitator and the goal of the intervention becomes one of building on client strengths through a much more client-directed process. In its most extreme representation, this takes the form of self-help/mutual aid strategies which draw on professional resources on an "as-needed" basis. More emphasis is placed upon mobilizing the users own personal-support system to avoid the problem of ongoing dependency.

At the same time, a more holistic approach to responding to the users necessitates multi-disciplinary and multi-sector responses. As efforts to move users out of large residential facilities continues, there is increased emphasis upon creating inclusive communities which welcome and support these individuals. From a structural point of view, issues of accessibility and service coordination have led to an increased interest in community-based multi-service centres as a primary vehicle for service delivery, rather than the traditional approach based on individual agencies operating out of central locations.

From a funding and management perspective, more traditional concerns about efficiency and financial controls have been replaced by a growing emphasis upon outcomes or community impacts as a basic unit of public accountability. This has been evident in the growing interest in the policy governance model among agencies, the initiatives from the local United Way with respect to impact statements and, on a larger scale, the adoption of "value-for-money" auditing processes within government.

To the extent that this represents an accurate, though cursory, exploration of the emerging model, it is remarkably similar to a model which has been developed and articulated within the Centre for Urban Affairs and Policy Research at Chicago's Northwestern University by Drs. John McKnight and Jody Kretzmann. As a result of considerable interest in this model, the Hamilton Community Foundation and the Social

Planning and Research Council co-sponsored a June 1994 workshop with Jody Kretzmann for local planners, funders and community representatives. The next section of this discussion paper will discuss their model, as it applies to local issues.

THE EMERGING MODEL

	OLD	NEW
SERVICE PHILOSOPHY	Counsellor as expert	Counsellor as Facilitator
	Focus on needs/problems	Focus on strengths
	Emphasis on one-to-one counselling	Multi-modalities
	Isolation from personal support systems	Mobilization of personal support systems
	Treatment	Prevention
	Professional-driven	Consumer-driven
SYSTEM STRUCTURE	Sector-specific ownership	Network-based
	Agency-based	Neighbourhood multi-service based
	Isolation/Segregation of clients	Inclusive communities
SYSTEM MANAGEMENT	Focus on activities	Focus on outcomes

COMMUNITY CAPACITY BUILDING

The purpose of elaborating upon this model in this discussion paper is not to suggest that this model should be adopted, in its present form, as a model for the local service system. Rather, it is of interest insofar as it appears to reflect many of the elements of the new model described above, which appears to be emerging from the evolution of our own human services system. It provides, therefore, an interesting focus or starting-point for important discussions about complex issues related to models of intervention.

To a very great extent, the capacity-building model which has been articulated by McKnight and Kretzmann represents a convergence of the two styles of intervention that marked human service during the late sixties and early seventies - the clinical model and the community-development model. It borrows elements from both to produce a "new" approach to responding to community problems. It is also notable that the model which they have articulated is empirically and experientially-based insofar as it has arisen from an analysis of "what was working" in a variety of different settings throughout the United States. It does not represent, therefore, a "theoretical" approach to social interventions.

Current approaches to human service interventions are criticized in this model for their tendency to be based on what is wrong or deficient in individuals and communities rather than being based on strengths, assets and capacities. The focus on needs and deficiencies as the starting point for human service interventions is viewed as having a number of damaging side-effects -

1. It leads to a very fragmented "need-by-need" approach to problem-solving which defies the conventional wisdom that problems are interwoven and symptomatic of a break-down in the capacity of the community for solving its problems.
2. The allocation of resources based on need tend to target resources to service providers rather than to the community and its residents.
3. Targeting resources to needs results in pressure to emphasize problems, de-emphasize capacities and denigrate communities in order to compete for scarce resources. This denigration becomes part of the problem, rather than the solution.
4. Providing resources based upon need underlines the perception that only outside professionals and experts can help a community.

5. The reliance on needs documentation creates a destructive cycle by creating a need to demonstrate the problems are worsening in order to justify continued resources.
6. Needs-based strategies tend to be individual and "survival-oriented" rather than strategies that mobilize the whole community.
7. The "survival" nature of these strategies rarely result in community change and reinforce a sense of hopelessness among persons using the system.

Although these criticisms of the dominant approach to human service interventions are based on American experiences in urban centres which are plagued with problems which are many times more serious than the local situation, it is notable how reflective they are of many of the concerns that have been raised about the traditional model in our community - fragmentation, dependency-inducing, professional dominance and so on.

The alternative approach to the traditional need-based model of service delivery which has been articulated in the work of Kretzmann and McKnight is the asset-based community-development model or "capacity-building".

At the level of individual interventions, the alternative approach does away with assessments that focus on problems, needs and diagnosis and begins, instead, with an "inventory" of the users strengths and assets and develops an intervention plan based upon those strengths and assets. The approach is best illustrated by an example provided by Kretzmann in his June 1994 speech at the Annual meeting of the Social Planning and Research Council. It concerned an attempt to work with discharged psychiatric patients in the Logan Square area of Chicago through the efforts of a worker named Rosita Delarosa and it is an excellent example of how this alternative model works in practice.

> "Rosita was a high school drop-out. Rosita's genius had two major elements. Rosita is someone... who can look at another human being...and sees the fullness. Some of us are trained to see the emptiness and start with the needs, the problems, the deficiencies. Rosita always starts with the gifts. And her second point of genius is that Rosita is someone who knows everybody in the neighbourhood and whom is trusted.
>
> What did she do? She went into the first of these homes where there were severely mentally challenged people living and she began introducing herself, meeting people and looking for gifts...She met Frank who was a 65 year old gentleman of Polish background who had lived in one of these homes and who had not spoken for the last thirty or forty years. Nobody had ever heard Frank speak. Rosita went in, introduced herself, sat with Frank for a half hour and was friendly. Not much response. She went back the next day, spent another half hour with Frank, was friendly, not much response. She went back a third day, was friendly and this time Frank took her hand and very gently led Rosita back to his room, where he lived in the back of the home....

> It was a dark and inhuman place. There were virtually no signs of human richness... But then....Rosita's eyes lit on something that was clearly the centre of the room. There it was on the mantle. It was a shiny, clearly cared for, bowling ball. Rosita then asked Frank a question that nobody in Franks sixty-five years of institutionalization, in the care of PhDs, psychologists, psychiatrists and helpers, had ever asked Frank before. What Rosita asked Frank was - Frank do you like to bowl? Frank just lit up. He grinned from ear to ear. He leapt off the bed, went over, grabbed the bowling ball, held it in front of Rosita, had Rosita put her fingers in the holes, smiling all the time. Rosita knew that she had found Frank's gift. Frank liked to bowl.
>
> What did Rosita, the community-building genius do? She went to her cousin who was the captain of a Puerto-Rican bowling league and her cousin said, sure, Frank can come out and bowl with us. So Frank became the seventh member of a six-member Puerto-Rican bowling team and he came every night and he rolled nothing but gutter balls. It was clear that he had not bowled in decades. After a few weeks he began knocking down a few pins and after five months one of the members left the team and Frank was asked to join as a regular member. In the meantime, he had begun to be invited over to the homes of some of the team members and he met their kids and spouses....After eight months, he began to speak for the first time. He didn't speak either English or Polish, he spoke Spanish because that was the language he had been hearing for the past eight months. He had obtained a third langauge."

The work of Rosita, which obviously stood in sharp contrast to traditional clinical responses to Frank's problems, is illustrative of some of the key elements of the capacity-building model, at the level of individual interventions - it commenced with an identification of Frank's gifts and interests, rather than his problems; it utilized existing community assets to help Frank mobilize those interests and Rosita acted as a facilitator rather than an expert, based on her knowledge and network within the community. In summary, a community asset (Rosita) was used to utilize another community asset (the bowling team) to foster Frank's development by identifying and building upon his interests and gifts. The outcome was a result that no clinical intervention had been able to accomplish in decades of interaction with Frank.

Precisely the same principles are applied to capacity-building at the community level. Rather than the more traditional approach which typically begins with a cataloguing of community problems and the use of resources to bring outside experts into the community to address these problems, the capacity-building model emphasizes the importance of beginning with an inventory of community assets and strengths and then using community resources to mobilize those internal assets and strengths to create a community which is reflective of the aspirations of the residents.

In its application, it makes use of a plethora of interventions and actions ranging from community-based economic development, to recreational and educational initiatives to mentoring and peer support programs. In doing so, it mobilizes all of the segments of the community. The common denominator of all of these activities is the emphasis upon utilizing the assets of the community to change the conditions which are at the root of the adverse issues which the community wants to address.

In summary, then, the notion of "capacity-building" and the model of interventions which are included within this notion appears to be reflective of the evolution in thinking which has been occurring, both locally and provincially, within our own service system. It does represent, however, a potential "revolution" in our current approach to service delivery insofar as much of the new "thinking" has not been translated into new services, to any great extent, because of a lack of funding for new initiatives. Much of our current service system, therefore, continues to operate on the basis of the traditional model because that is what "they are paid to do".

The next section of this discussion paper will briefly highlight some of the key issues which would need to be addressed in discussions pertaining to the implementation of a new model for human services in Hamilton-Wentworth.

THE FUTURE HUMAN SERVICES SYSTEM

The purpose of this section of the report is to attempt a tentative description of the future human services system in Hamilton-Wentworth if it continues to evolve toward a capacity-building model, given the trends and description of the model provided in earlier sections of this discussion paper.

Structurally, the system would be based upon a number of community and neighbourhood multi-service centres which would act as the site for the delivery of most services. Each centre would host staff from a variety of different agencies, probably on a part-time basis. Each centre would also contain a centralized intake and assessment process for persons utilizing the centre. Individual agencies could continue to operate in the community but front-line staff from those agencies would spend relatively little time in the agency's offices as service delivery shifted to the community service centres. It is noteworthy that, from a structural perspective, this is precisely the model that local providers of long-term care services are recommending as an alternative to the Province's model which would effectively close down existing agencies and replace them with one large multi-service agency.

The programs offered within the community service centres would be heavily influenced by local residents, subject to Regional and Provincial guidelines, through the creation of local boards or advisory groups. Given that some recent experiences with neighbourhood associations have been more exclusionary than inclusionary in nature, safeguards would need to be developed to ensure that all community-residents had a voice in the centre's activities and to ensure that the interests of a variety of marginalized populations are addressed. The need to ensure some equity of access across the Region would also necessitate the development of basic service standards which would have to be met within each centre. Experiences documented by McKnight and Kretzmann in the United States have indicated that such an approach is possible.

The primary purpose of these centres would <u>not</u> be one of simply bringing clinical services "closer to home" as previous models of multi-service centres have often represented. The primary purpose, rather, would be one of building the capacity of the community to address the issues which are of concern to the residents. The emphasis, therefore, would be upon changing the factors in the community which give rise to problems rather than simply responding to the problems. The emphasis would also be upon utilizing the resources which exist in the community to address those issues. These resources would include

professionals, individual residents, service clubs, churches, schools, recreational programs and any other assets contained in the host community.

Each centre would probably contain a strong volunteer component and a primary emphasis upon community development interventions which utilized indigenous residents. Although the centres would receive staff support from existing agencies, the type of work performed by these staff may differ dramatically from current interventions. Less time would be spent with traditional counselling modalities and more time would be spent facilitating and supporting other modalities such as self-help/mutual aid, skill-building programs, mentoring programs, peer support programs or support to indigenous staff/volunteers. It is difficult to precisely anticipate the type of service mix which would grow out of these centres but it is probably safe to assume that it might look significantly different from the services offered at present.

IMPLICATIONS

In times of dramatic change, there is always a danger that the enthusiasm for the "new" will result in an over-reaction against the "old". In shifting the emphasis within our own community, it would be critical that we not "throw out the baby with the bath water". **There is no suggestion, therefore, that traditional models of intervention should be eliminated from the human services landscape.** What may be needed, however, is an end to the almost total dominance of traditional models with a more balanced system that offers a variety of interventions in a community that is becoming increasingly diverse in its own preferences. It is noteworthy that most of the new initiatives in our community during the past few years have been of a "capacity-building" nature and they have arisen from the current service system.

At the same time, however, it must be recognized that the fostering of capacity-building approaches will not result from an influx of new funds into the system. It will only occur if a transfer of resources from traditional services to new capacity-building initiatives is undertaken. This is precisely the course of action which is being undertaken, to some extent, in the health sector as clinical expenditures are being curbed to create resources for population-based measures. A serious adoption of capacity-building interventions in social services would require the same kind of transfer of resources from traditional to capacity-building initiatives. In the final analysis, it may turn out that the same agencies are offering the services but the kind of services they are offering may be very different from current programs. It will, therefore, become extremely important to intelligently identify those problems or those clients for whom traditional clinical interventions are of critical importance.

The adoption of new models also has serious human resource implications, given the predominance of clinical social workers, psychologists and other professions in the social services system. The skill requirements of capacity-building models may be very different from those of current approaches and staff disruption and re-training issues may arise as major factors. Most social service and social work students continue to be schooled in the skills of traditional interventions.

From a funding and accountability perspective, capacity-building initiatives represent a very different scenario from the current practice of funding an agency to provide X hours of counselling units for Y dollars per unit. A serious attempt to develop outcome or impact funding programs would appear to be needed to replace current practices of funding activity units. There will also be key accountability issues pertaining

to the roles of funders and agency boards in a system which allocates increased authority to residents and service consumers. These issues, however, are not new to the agency community and many organizations are already undergoing adjustments arising from the increasing need for consumer participation.

CONCLUSIONS

This paper represents a qualitative attempt to interpret a number of the trends which are affecting the development of human services in Hamilton-Wentworth and to develop a descriptive scenario of the future human services system if these trends continue. If this scenario, or some derivative of it, is reflective of the future, then it is a future for which we should actively plan and prepare. Although it is not "revolutionary" insofar as it does reflect general directions which are already present in the system of services, it does reflect a fundamental change in both the philosophy and structure of the human services system. There are important implications at all levels of the system - funding, accountability, delivery, human resources and education.

It is important that we anticipate and effectively address these implications to avoid a process of "change through chaos".

Some of the critical steps in this process would include:

1. A community-wide discussion about the extent to which this future scenario does reflect the aspirations of the community and the many components which comprise it.
2. A careful feasibility study of structurally changing the system from one based on centralized and specialized agencies to one based on community multi-service centres.
3. A careful review of the role of traditional services within the scenario.
4. A review of the human resource implications of evolving models which would include the educational facilities which are currently involved in training existing and future human service workers.
5. The identification and analysis of governance and advisory models which would ensure that some population groups are not excluded from participating in the multi-service centres.

If the current human services system is in danger of "irrelevancy" as a result of the various serious changes that have occurred in the community, then it is clearly necessary to consider the need for fundamental change in our approach to service delivery. This is a proposition which has been receiving considerable discussion in our community in recent times and this paper has been prepared to provide an opportunity for focussing that discussion into a constructive process for change which will address the rising concerns about the role of services in Hamilton-Wentworth.